F. Calculation of Coinsurance Payments and Medicare Program Payments Under the PPS

1. Background

In section III.E, above, we explained how we determined APC group weights, calculated an outpatient PPS conversion factor, and determined national prospective payment rates, standardized for area wage variations, for the APC groups. We will now explain how we calculated beneficiary coinsurance amounts for each APC group.

The outpatient PPS established by section 1833(t) of the Act includes a mechanism designed to eventually achieve a beneficiary coinsurance level equal to 20 percent of the prospectively determined payment rate established for the service. As discussed in the proposed rule, for each APC we calculate an amount referred to in section 1833(t)(3)(B) of the Act as the "unadjusted copayment amount." The unadjusted coinsurance amount is calculated by taking 20 percent of the national median charges billed in 1996 for the services that are in the APC, trended forward to 1999; however, the coinsurance amount cannot be less than 20 percent of the APC payment rate. The unadjusted coinsurance amount for an APC remains frozen, while the payment rate for

the APC is increased by adjustments based on the Medicare market basket. As the APC rate increases and the coinsurance amount remains frozen, the unadjusted coinsurance amount will eventually become 20 percent of the payment rate for all APC groups. Once the unadjusted coinsurance amount is 20 percent of the payment amount, both the APC payment rate and the unadjusted coinsurance amount will be updated by the annual market basket adjustment.

In the proposed rule, we proposed to not adopt new APCs for new procedures or services for at least 2 years, but instead assign them to existing groups while accumulating data on their costs. In the final rule we do provide for APCs for new procedures that do not fit well into another APC. When an APC is added that consists of HCPCS codes for which we do not have 1996 charge data upon which to calculate the unadjusted coinsurance amount, coinsurance will be calculated as 20 percent of the APC payment amount.

There is an exception to the coinsurance provisions for screening colonoscopies and screening sigmoidoscopies. Section 4104 of the BBA 1997 provided coverage for colorectal screening. This section, in part, added new sections 1834(d)(2) and (3) to the Act, which provide that

for covered screening sigmoidoscopies and colonoscopies performed in hospital outpatient departments and ambulatory surgical centers (ASCs), payment is to be based on the lesser of the hospital or the ASC payment rates and coinsurance for both screening colonoscopies and screening sigmoidoscopies is to be 25 percent of the rate used for payment.

Section 4104 of the BBA 1997 also allows, at the Secretary's discretion, coverage of screening barium enemas as a colorectal cancer screening tool. We are including screening barium enemas as a covered service under the hospital outpatient PPS. The payment rate for screening barium enemas is the same as for diagnostic barium enemas. Coinsurance for a screening barium enema is based on 20 percent of the APC payment rate.

Sections 201(a) and (b) of the BBRA 1999 amend section 1833(t) of the Act to provide for additional payments to hospitals for outlier cases and for certain medical devices, drugs, and biologicals. These additional payments to hospitals will not affect coinsurance amounts. Redesignated section 1833(t)(8)(D) of the Act, as amended by section 201(i) of the BBRA 1999, provides that the coinsurance

amount is to be computed as if outlier adjustments, adjustments for certain medical devices, drugs, and biologicals, as well as any other adjustments we may establish under section 1833(t)(2)(E) of the Act, had not occurred. Section 202 of the BBRA 1999 adds a new section 1833(t)(7) to the Act to provide transitional corridor payments to certain hospitals through calendar year 2003 and indefinitely for certain cancer centers. Section 1833(t)(7)(H) of the Act provides that the transitional corridor payment provisions will have no effect on determining copayment amounts.

Section 204(a) of the BBRA 1999 amended redesignated section 1833(t)(8)(C) of the Act to provide that the coinsurance amount for a hospital outpatient procedure cannot exceed the amount of the inpatient hospital deductible for that year. The inpatient hospital deductible for calendar year 2000 is $776.00. We will apply the limitation to the wage adjusted coinsurance amount (not the unadjusted coinsurance amount) after any Part B deductible amounts are taken into account. Therefore, although the published unadjusted coinsurance amount for any APC may be higher or lower than $776.00 in 2000, the actual coinsurance

amount for an APC, determined after any deductible amounts and adjustments for variations in geographic areas are taken into account, will be limited to the Medicare inpatient hospital deductible. Any reductions in copayments that occur in applying the limitation will be paid to hospitals as additional program payments. (See section III.F.3.a, below, for discussion of calculating the Medicare payment amount.)

MedPAC Comment: In its March 1999 report to the Congress, MedPAC expressed concern that the statute's approach to addressing the reduction in coinsurance could mean that it will be decades before coinsurance is 20 percent of all APC payment rates. MedPAC recommended that the Secretary seek and the Congress legislate a more rapid phase-in and that the cost be financed by increases in program spending, rather than through additional reductions in payments to hospitals. MedPAC agrees that the approach to calculating the coinsurance delineated in section 1833(t) of the Act is methodologically sound, but they recommend a shorter period to complete the coinsurance reduction.

Response: The coinsurance reductions enacted by the BBA 1997 already provide significantly higher levels of

financial protection for beneficiaries than have existed in the past. While an acceleration of this protection might be desirable, the costs of such a policy must be balanced against other needs for increased Medicare spending and protection of the trust funds. The President's budget for FY 2001 does not contain such a proposal.

Comment: Three commenters discussed the delay in implementing the outpatient PPS until after January 1, 2000. A hospital association stated that it strongly believes that the outpatient PPS should not be implemented until all systems are ready, and suggested that implementation occur at the start of a calendar year so that Medigap insurers did not receive an unearned windfall by reason of a midyear decrease in beneficiary coinsurance amounts. Stating that the delay in implementation was of serious concern to it, an insurance group strongly urged us to implement the outpatient PPS as soon as possible. Finally, a beneficiary advocacy group stated that it is deeply concerned about the delay in implementation. While stating that it understood the magnitude of the Y2K problem, this group urged us to find a way to proceed with the phase-down of beneficiary

coinsurance or, failing that, to offer our assurance that the phase-down will not be delayed beyond January 1, 2000.

Response: As noted elsewhere in this final rule, we intend to implement the outpatient PPS effective for services furnished on or after July 1, 2000. As noted in the proposed rule, we concluded that attempting to make the massive computer changes required to implement PPS at the same time we were trying to ensure that Medicare's computers were Y2K compliant would have jeopardized the compliance effort, which was HCFA's highest priority. Now that HCFA's efforts to make its computer systems, and those of its contractors, Y2K compliant are complete, we believe that July 1, 2000 is the earliest date on which we can feasibly implement the PPS. Pursuant to HCFA's contracts with the contractors responsible for maintaining its computer systems, HCFA makes programming changes such as those required to implement the outpatient PPS at the beginning of fiscal quarters. Thus, pursuant to this practice, after January 1, 2000, there are only three dates in 2000 on which the programming changes necessary to implement outpatient PPS can be put into effect -- April 1, 2000, July 1, 2000 and October 1, 2000.

The first step in changing HCFA’s computer systems to allow for implementation of the outpatient PPS is to expand the claim record of several HCFA and contractor systems to accept and retain specific information related to how a service is being paid or why it is denied. The claim record expansion is an indispensable prerequisite to implementation of outpatient PPS. Once expansion of the claim form is completed, we can then make the remaining programming changes necessary to implement the outpatient PPS. As we noted in the proposed rule, 63 FR 47605, these are massive changes that will require extensive testing. We anticipate that these software coding changes cannot be completed before the end of the second quarter of 2000. Therefore, the earliest possible date on which they can be installed and made operational is July 1, 2000.

We do not believe that it is technically feasible to complete installation of both the claims-form line item expansion and the coding changes needed to implement PPS any sooner than July 1, 2000. Each of these two stages of preparing HCFA's computer system for PPS constitutes major systems changes in and of itself. To attempt to make both changes simultaneously would be to run the risk that the

system would not function properly at all, potentially requiring implementation to be delayed beyond July 1, 2000. We believe that the two-stage approach discussed above is the only feasible way to make the systems changes necessary to implement PPS and to be certain that they will work. The soonest date on which PPS can be implemented after the millennium is therefore July 1, 2000.

Despite one commenter's request that we implement the outpatient PPS at the start of a calendar year, we do not believe it would be appropriate to delay implementation beyond July 1, 2000. We see no reason to delay implementation beyond the time necessary for HCFA to have completed its Y2K efforts and make all the systems changes necessary for PPS. As with all of the other aspects of PPS, we believe that the beneficiary coinsurance reform contained in the outpatient PPS should be put into effect as soon as possible, so that beneficiaries can be subject to the lower coinsurance amounts under the new payment methodology at the earliest date. We believe that this consideration outweighs any concern that Medigap insurers might receive a windfall because they set premiums for a given year assuming coinsurance amounts would be at one level only to see those

amounts decrease in the middle of the year. In addition, we note that, if insurers received a large enough windfall for the reasons described by the commenter, the insurers might be required to refund premiums to beneficiaries or offer them a credit on premiums pursuant to section 1882(r) of the Act.

While none of the commenters specifically requested that we do so, we have considered the possibility of applying the outpatient PPS payment methodology retroactively to services furnished on or after January 1, 1999. We have decided not to make these retroactive payments for the reasons described below.

The first reason is the practical problem that the information needed to implement PPS retroactively does not exist in a usable form. Under current payment methodologies for many outpatient services, hospitals submit bills for furnished services based on their charges for the services. For these services, HCFA does not require hospitals to submit bills containing the HCPCS code for the furnished service and other data (such as the dates of service of multiple services submitted on the same bill) necessary to process bills under the new prospective payment methodology.

Without the HCPCS code for a given service, we would be unable to determine retroactively into which APC group the service should be placed for payment under PPS. In turn, that would mean that we could not determine the appropriate payment amount for the service. Thus, given the information currently available to us, we could not now simply reprocess bills for outpatient services that had been furnished between January 1, 1999 and July 1, 2000 and recompute payment and coinsurance amounts for these services. As a result, the data needed to implement PPS retroactively do not exist in a form that would allow for such implementation.

Nor would it have been feasible to attempt to capture the information necessary for retroactive application during 1999. As noted above, we concluded that it would not have been prudent to make the computer programming changes necessary to implement PPS until our Y2K efforts were complete. Those same changes would have been necessary to allow us to capture the more detailed claims data needed to perform a retroactive application of PPS back to January 1, 1999 once the system was implemented prospectively. Because we delayed those changes out of concern that they would

interfere with our Y2K efforts, no automated process existed for the period January 1, 1999 through July 1, 2000 by which we could have captured the more detailed claims data necessary to effect an eventual retroactive implementation of PPS. Publication of a final rule before January 1, 1999 would not have altered this situation. Even if we had published such a rule, it could not have become effective until we could make the computer changes necessary to implement PPS--the functional equivalent of what we have done through publication of the proposed rule and this final rule--and until we could make those changes, we could not compile by computer the data needed to later reprocess claims under PPS.

In theory, we might have been able to implement PPS retroactively despite the lack of an automated method of compiling the data necessary to do so. But it simply would not have been practicable to maintain and later process by hand such data for the period between January 1, 1999 and July 1, 2000, given the millions of claims for outpatient services submitted during that period. (Based on the latest data available, we process approximately 160 million claims for outpatient services over an 18-month period.) Neither

HCFA nor its contractors have the staff needed to accomplish such a task.

We might also have conceivably required hospitals to maintain the data required for a later retroactive implementation of PPS, but this approach has practical difficulties. First, during the interim period between January 1, 1999 and implementation of PPS, hospitals themselves were exerting significant efforts to ensure the Y2K compliance of their own automated Medicare billing systems, and it is doubtful that those systems could have accommodated the necessary programming changes any more than Medicare's systems could have. Even if hospitals could have maintained the information (or if HCFA could have maintained it by hand or could obtain it from any source now), the burden associated with attempting to implement the new prospective payment methodology both retroactively and prospectively at the same time would have been prohibitive. As noted in the proposed rule and in this final rule, effecting the transition between the old payment methodologies and the new prospective payment methodology constitutes a massive programmatic undertaking. Any effort to reprocess the huge number of bills for outpatient

services that would be involved in any attempt to retroactively implement PPS would compete for the same resources needed to implement PPS prospectively, and would compromise our ability to ensure the smoothest prospective implementation.

This is especially so if paper records of claims from the interim period would have to be manually input into Medicare's automated payment systems in order to make retroactive payments for services furnished on or after January 1, 1999. Undertaking an effort, once PPS is implemented, to review hospital records of every outpatient service furnished between January 1, 1999 and July 1, 2000; translate those records into the data needed to process a Medicare claim for the service under PPS; and issue a retroactive payment reflecting the PPS rate for the service would cause a huge backlog of current bills to be processed (and of other carrier tasks), and thus would not be practicable. Therefore, there was no feasible way to have captured the information necessary to make PPS apply retroactively.

In addition to the practical problems described above, the statute does not require retroactive application of PPS.

The statutory requirement to implement the PPS for services furnished on or after January 1, 1999 is ambiguous. While section 1833(t)(1)(A)'s reference to outpatient services "furnished during a year beginning with 1999" might be read as imposing such a requirement, it is also true that section 1833(t)(1)(B)(i) does not expressly set a time limit for HCFA to designate which services are "covered" outpatient services for purposes of payment under PPS. Nor does it set a deadline for HCFA to issue regulations implementing the outpatient PPS. As a result, the statute can also be read to require implementation of PPS for services furnished in a year beginning in 1999 <u>if</u> HCFA has designated in its implementing regulations those services as covered services for purposes of PPS. The better reading is that the system applies prospectively only.

We recognize that, under section 1833(a)(2)(B), Congress arguably made the old payment methodologies for outpatient services inapplicable to services furnished on or after January 1, 1999. Again, though, Congress imposed no corresponding limit on the time within which HCFA must designate the services that would be "covered" services for purposes of PPS. While it is therefore possible to read the

statute in such a way that an outpatient service furnished after January 1, 1999 but not yet designated as a covered outpatient service by HCFA for purposes of PPS would have no payment methodology applicable to it, we do not believe that Congress intended such a result. We believe that where HCFA, because of significant Y2K concerns, has not yet designated a given outpatient service as a covered service for purposes of PPS, the most appropriate reading of section 1833(t)(1)(A) is that it authorizes the Secretary to continue to pay for the service under the existing methodology until PPS can be implemented. If the Congress had known about the Y2K problem at the time it enacted the PPS statute, this is the only rational approach it could have adopted.

We believe that a clear expression of Congressional intent not to require retroactive application of PPS can be found in the legislative history of amendments to section 1833(t) of the Act, enacted as sections 201, 202, and 204 of the BBRA 1999. In each instance, the legislation provides that the "amendments made by this section shall be effective as if included in the enactment of the BBA," that is, the original enactment of PPS in section 1833(t) (sections

201(m), 202(b), and 204(c) of the BBRA 1999). This language was taken from the House version of the bill (H.R. Rep. No. 436 (Part I), 106th Cong., 1st Sess. 14, 16 (1999)). The House Report stated that the outpatient payment reforms contained in the BBRA 1999 (and hence in the BBA 1997) were intended to take effect “upon implementation of the hospital prospective payment system” by HCFA, id. at 52, 55, 56, not on January 1, 1999. The House Conference Committee Report reiterated the understanding that the payment and coinsurance provisions of the BBA and BBRA do not take effect until after implementation by HCFA. H. Conf. Rep. No. 479, 106th Cong., 1st Sess. 866 (1999) ("[c]urrently, beneficiaries pay 20% of charges for outpatient services," but "[u]nder the outpatient PPS, beneficiary coinsurance will be limited to frozen dollar amounts based on 20% of national median charges for services in 1996, updated to the year of implementation of the PPS"); id. at 867 ("[t]he conferees fully expect that the beneficiary coinsurance phase-down will commence, as scheduled, on July 1, 2000"); 870 ("[h]ospital outpatient PPS is to be implemented simultaneously and in full for all services and hospitals (estimated for July 2000)").

Both the House Report and the Conference Report expressly acknowledge, without disapproval, HCFA's decision to delay implementation of the outpatient PPS until after January 1, 2000. H.R. Rep. No. 436 (Part I) at 51 (stating that Secretary "delayed implementation of the new system until after the start of CY 2000 in order to ensure that 'year 2000' data processing problems are fully resolved before the new system is implemented" and that "HCFA currently estimates that the outpatient department prospective payment system will be implemented in July 2000"); 145 Cong. Rec. at H12529 (daily ed. Nov. 17, 1999) (H. Conf. Rep. No. 479) (acknowledging "[t]here has already been a one-year delay in implementation of the BBA 97 provision" and stating that conferees "fully expect" that the outpatient prospective payment system "will commence, as scheduled, on July 1, 2000"). These statements indicate Congressional intent that payments and coinsurance for covered hospital outpatient services would be governed prospectively by PPS only after HCFA promulgated and made effective final implementing regulations.

Finally, there is a serious question as to whether retroactive implementation of PPS might constitute

prohibited retroactive rulemaking. In Bowen v. Georgetown University Hospital, 488 U.S. 204, 208 (1988), the Supreme Court stated that a statutory grant of legislative rulemaking authority does not encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms, even where some substantial justification for retroactive rulemaking might exist. The Court then declined to find this express authorization for retroactive rulemaking in the Medicare statute's general grant of rulemaking authority.

We do not find this express authorization in section 1833(t) or any other statutory provision concerning the outpatient PPS. Section 1833(t)(1) requires that payment for outpatient services that are furnished during any calendar year beginning after January 1, 1999 and that are designated by HCFA as "covered" outpatient services shall be made under a prospective payment system. While Congress may have presumed, when it enacted section 1833(t) as part of the BBA, that HCFA would be able to designate covered outpatient services and implement the outpatient PPS by January 1, 1999, Congress did not foresee at that time that Y2K concerns would prevent the agency from doing so. As a

result, the statute is silent as to what was to occur if HCFA was unable to designate covered outpatient services and implement PPS by January 1, 1999. We do not believe that this silence constitutes the express authorization of retroactive rulemaking required by the Supreme Court's Georgetown decision.

Comment: Several commenters contended that the proposed rules for beneficiary coinsurance are overly complex and that the phase-in period is too long. One commenter asked HCFA to consider a less involved method and a more aggressive time period for implementation. Another commenter suggested using a 5-year phase-in period. One commenter requested that we recommend a legislative change to the Congress to reduce beneficiary coinsurance to 20 percent by January 1, 2003. Still another commenter expressed concern that calculations of coinsurance amounts for each hospital will be particularly burdensome to Medicare fiscal intermediaries and, as a result of the increased workload, errors may occur. The commenter also recommended a more rapid reduction of coinsurance to 20 percent of the payment amount.

Response: We agree that the rules governing how coinsurance is to be calculated under the PPS are complex, and the phase-in to 20 percent coinsurance is a lengthy one. However, the methods for calculating coinsurance are dictated by the statute. The legislative changes were made in order to put some control on rapidly increasing beneficiary coinsurance payments, to begin to decrease the proportion of beneficiary liability for hospital outpatient services, and to continue to reduce beneficiary liability over time. As we have stated, the impetus to accelerate the reduction of beneficiary coinsurance has to be viewed within the context of other needs for increased Medicare expenditures and long-term protection of the trust funds. The delay in implementing the hospital outpatient PPS past the statutory effective date was unavoidable due to systems constraints imposed by Y2K compliance requirements.

Comment: One commenter noted that the proposed rule set beneficiary coinsurance at 20 percent of median charges, but the commenter believes that coinsurance amounts should be recalculated to equal 20 percent of the average charge for the applicable APC group. The commenter indicates that

such a change would provide some financial relief to hospitals.

Response: Section 1833(t)(3)(B)(i) of the Act requires that unadjusted coinsurance amounts be calculated as 20 percent of the national median of the charges for services within the APC group.

Comment: One commenter stated that because coinsurance is based on the median charges of the APC, some beneficiaries would pay a higher coinsurance than they would under the current system. The commenter believes that beneficiaries who require less intensive services in an APC group will essentially subsidize other beneficiaries who receive more intensive services within the group. The commenter asserted that fairness would dictate beneficiaries be charged coinsurance amounts that more appropriately reflect the services received, not an amount based on a median of multiple services they did not receive.

Response: Section 1833(t)(3)(B)(ii) of the Act provides that the unadjusted coinsurance amounts are based on the national median of the charges for the "services within" an APC. Because an APC group consists of services that are both clinically similar and similar with respect to

the resources required to perform the service, we would expect that charges for the services should also be fairly homogeneous. We believe that services within a group are homogeneous enough to warrant a single payment amount and a single coinsurance amount.

In the following sections, we describe how we determined the beneficiary coinsurance amount and the Medicare program payment amount for services paid for under the hospital outpatient PPS.

2. Determining the Unadjusted Coinsurance Amount and Program Payment Percentage

To calculate Medicare program payment amounts and beneficiary coinsurance amounts, we first determined for each APC group two base amounts, in accordance with statutory provisions:

! An unadjusted copayment amount, described in section 1833(t)(3)(B) of the Act; and

! The predeductible payment percentage, which we call the program payment percentage, described in section 1833(t)(3)(E) of the Act.

a. Calculating the Unadjusted Coinsurance Amount for Each APC Group

In the proposed rule, we described the specific steps used to calculate the unadjusted coinsurance amounts for each APC group as follows:

(i) We determined the national median of the charges billed in 1996 for the services that constitute an APC group after standardizing charges for geographic variations attributable to labor costs. (To determine the labor adjustment, we divided the portion of each charge that we estimated was attributable to labor costs (60 percent) by the hospital's inpatient wage index value and added the result to the nonlabor portion of the charge (40 percent)).

(ii) We updated charge values to projected 1999 levels by multiplying the 1996 median charge for the APC group by 13.0 percent (increased to 14.7 percent in this final rule), which the HCFA Office of the Actuary estimates to be the rate of growth of charges between 1996 and 1999.

(iii) To obtain the unadjusted coinsurance amount for the APC group, we multiplied the estimated 1999 national median charge for the APC group by 20 percent. The unadjusted coinsurance amount is frozen at the 1999 level until such time as the program payment percentage (as

determined below) equals or exceeds 80 percent (section 1833(t)(3)(B)(ii) of the Act).

b. Calculating the Program Payment Percentage (Predeductible Payment Percentage)

In the proposed rule and in this final rule, we use the term "program payment percentage" to replace the term "pre-deductible payment percentage," which is referred to in section 1833(t)(3)(E) of the Act. The program payment percentage is calculated annually for each APC group, until the value of the program payment percentage equals 80 percent. To determine the program payment percentage for each APC group, we--

(i) Subtract the APC group's unadjusted coinsurance amount from the payment rate set for the APC group; and

(ii) Divide the difference (APC payment rate minus unadjusted coinsurance amount) by the APC payment rate, and multiply by 100.

The program payment percentage will be recalculated each year because APC payment rates will change when APC rates are increased by annual market basket updates and whenever we revise an APC.

Comment: One commenter expressed concern about how the coinsurance amounts are determined. The commenter stated that the calculation is flawed and penalizes beneficiaries in those States where charges for services tend to be lower than in other States. The commenter alleged that if the hospitals in those States where charges for services tend to be lower accept a reduced coinsurance in order to hold beneficiaries harmless, the hospitals will be penalized. The commenter also asserted that Medigap policies and Medicaid programs will also be affected. The commenter further stated that coinsurance should be based on regional, not national, charges. The commenter contended that the provision does not achieve the intended outcome of equalizing payment across the nation.

Response: Sections 1833(t)(3) and (t)(8) of the Act prescribe how coinsurance amounts are to be calculated under the PPS. Our method of calculating unadjusted coinsurance amounts for each APC group based on 20 percent of national median charges follows the requirements of section 1833(t)(3)(B) of the Act.

Comment: A number of commenters believe that the payment system as proposed would create gross anomalies in

coinsurance for particular chemotherapy drugs. For example, the proposed $36.61 coinsurance for fluorouracil is 10 times the hospital's cost to purchase that drug. The commenters asserted that this excessive coinsurance represents an abuse of patients and would undermine beneficiary confidence in the new system. They recommended that coinsurance be limited to 20 percent of the payment amount for each drug.

Several other commenters noted that classifying drugs with widely varying costs in the same APC will have a significant negative effect on beneficiary coinsurance, and in some cases beneficiaries could be required to pay a greater percentage of coinsurance for less effective therapies. For example, one commenter alleged that the coinsurance for the drug 5-FU, which the commenter believes has a current coinsurance of approximately $1, would increase to $40 under the proposed system.

Response: The coinsurance anomalies for chemotherapy drugs that appeared in the proposed rule are not an issue under this final rule. Unlike the proposed chemotherapy drug APCs, which grouped all chemotherapy drugs under four APCs, in this final rule, each chemotherapy drug is assigned to a separate APC. As discussed in section III.D.5 of this

preamble, the unadjusted coinsurance amounts for these APCs is calculated as 20 percent of the APC payment rate.

Comment: One commenter noted that the proposed national unadjusted coinsurance amounts for cardiovascular stress testing and perfusion imaging result in beneficiaries bearing 85 percent of the total payment for stress testing and 60 percent for perfusion imaging, which many beneficiaries will be unable to afford. Another commenter requested that we either exclude cataract procedures and angioplasty from the hospital outpatient PPS or create an outlier policy that affords special treatment for these procedures in order to protect beneficiaries from excessive coinsurance amounts.

Response: Coinsurance amounts, by law, are based on 20 percent of the median of the charges actually billed in 1996 (updated to 1999) for the services within an APC. The fact that coinsurance is a larger proportion of the total payment for some APCs than for others reflects the differences in hospital charging practices for different services. For example, in examining departmental cost-to-charge ratios reflected on hospital cost reports, we have found that most hospitals have higher mark-ups in charges

for radiology and diagnostic services than they do for clinic visits.

3. Calculating the Medicare Payment Amount and Beneficiary Coinsurance Amount

a. Calculating the Medicare Payment Amount

The national APC payment rate that we calculate for each APC group is the basis for determining the total payment (subject to wage-index adjustment) the hospital will receive from the beneficiary and the Medicare program. (A hospital that elects to reduce coinsurance, as described below in section III.F.4, may receive a total payment that is less than the APC payment rate.) The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. In addition, the amount calculated for an APC group applies to all the services that are classified within that APC group. The Medicare payment amount for a specific service classified within an APC group under the outpatient PPS is calculated as follows:

(i) Apply the appropriate wage index adjustment to the national payment rate that is set annually for each APC group.

(ii) Subtract from the adjusted APC payment rate the amount of any applicable deductible as provided under §410.160.

(iii) Multiply the adjusted APC payment rate, from which the applicable deductible has been subtracted, by the program payment percentage determined for the APC group or 80 percent, whichever is lower. This amount is the preliminary Medicare payment amount.

(iv) If the wage-index adjusted coinsurance amount for the APC is reduced because it exceeds the inpatient deductible amount for the calendar year, add the amount of this reduction to the amount determined in (iii) above. The resulting amount is the final Medicare payment amount.

b. Calculating the Coinsurance Amount

A coinsurance amount is calculated annually for each APC group. The coinsurance amount calculated for an APC group applies to all the services that are classified within the APC group. The beneficiary coinsurance amount for an APC is calculated as follows:

Subtract the APC group's Medicare payment amount from the adjusted APC group payment rate less deductible; for example, coinsurance amount = (adjusted APC group

payment rate less deductible) - APC group preliminary Medicare payment amount. If the resulting amount does not exceed the annual hospital inpatient deductible amount for the calendar year, the resulting amount is the beneficiary coinsurance amount. If the resulting amount exceeds the annual inpatient hospital deductible amount, the beneficiary coinsurance amount is limited to the inpatient hospital deductible.

For example, assume that the wage-adjusted payment rate for an APC is $300; the program payment percentage for the APC group is 70 percent; the wage-adjusted coinsurance amount for the APC group is $90; and the beneficiary has not yet satisfied any portion of his or her $100 annual Part B deductible.

(A) Adjusted APC payment rate: $300

(B) Subtract the applicable deductible:

$300 - $100 = $200

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount:

0.7 x $200 = $140

(D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount, which cannot exceed the inpatient hospital deductible for the calendar year:

$200 - $140 = $60

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation.

$140 + $0 = $140

In this case, the beneficiary pays a deductible of $100 and a $60 coinsurance, and the program pays $140, for a total payment to the hospital of $300. Applying the program payment percentage ensures that the program and the beneficiary pay the same proportion of payment that they would have paid if no deductible were taken.

If the annual Part B deductible has already been satisfied, the calculation is:

(A) Adjusted APC payment rate: $300

(B) Subtract the applicable deductible:

$300 - 0 = $300

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount:

0.7 x $300 = $210

(D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the amount of the inpatient hospital deductible for the calendar year:

$300 - $210= $90

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation.

$210 + $0 = $210

In this case, the beneficiary makes a $90 coinsurance payment, and the program pays $210, for a total payment to the hospital of $300.

The following example illustrates a case in which the inpatient hospital deductible limit on coinsurance amounts applies. Assume that the wage-adjusted payment rate for an

APC is $2,000; the wage-adjusted coinsurance amount for the APC is $900; the program payment percentage is 55 percent; the inpatient hospital deductible amount for the calendar year is $776 and the beneficiary has not yet satisfied any portion of his or her $100 Part B deductible.

(A) Adjusted APC payment rate: $2,000

(B) Subtract the applicable deductible:

$2000 - $100 = $1,900

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount:

0.55 x $1,900 = $1,045

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the inpatient hospital deductible amount of $776:

$1,900 - $1,045 = $855, but coinsurance limited to $776

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the

coinsurance was reduced as a result of the inpatient hospital deductible limitation ($855 - $776 = $79).

$1045 + $79 = $1,124

In this case, the beneficiary pays a deductible of $100 and coinsurance that is limited to $776. The program pays $1,124 (which includes the amount of the reduction in beneficiary coinsurance due to the inpatient hospital deductible limitation) for a total payment to the hospital of $2,000.

4. Hospital Election to Offer Reduced Coinsurance

For most APCs, the transition to the standard Medicare coinsurance rate (20 percent of the APC payment rate) will be gradual. For those APC groups for which coinsurance is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. The law offers hospitals, but not CMHCs, the option of electing to reduce coinsurance amounts and permits hospitals to disseminate information on their reduced rates. In this section, we discuss the procedure by which hospitals can elect to offer a reduced coinsurance amount, and the effect of the election on calculation of the program payment and beneficiary coinsurance.

Section 1833(t)(5)(B) of the Act, as added by section 4523 of the BBA 1997, requires the Secretary to establish a procedure under which a hospital, before the beginning of a year, may elect to reduce the coinsurance amount otherwise established for some or all hospital outpatient services to an amount that is not less than 20 percent of the hospital outpatient prospective payment amount. The statute further provides that the election of a reduced coinsurance amount will apply without change for the entire year, and that the hospital may disseminate information on its reduced copayments. Section 1833(t)(5)(C) of the Act, as added by the BBA 1997, provides that deductibles cannot be waived. Finally, section 1861(v)(1)(T) of the Act (as added by section 4451 of the BBA 1997) provides that no reduction in coinsurance elected by the hospital under section 1833(t)(5)(B) of the Act may be treated as a bad debt. We note that section 1833(t)(5) of the Act has been redesignated as section 1833(t)(8) of the Act by sections 201(a) and 202(a) of the BBRA 1999.

Elections to reduce coinsurance will not be taken into account in calculating transitional corridor payments to hospitals (discussed in section III.H.2 of this preamble).

That is, a hospital's transitional corridor payment will be determined as if the hospital received unreduced coinsurance amounts from beneficiaries.

In the proposed rule, we stated that we would require that hospitals make the election to reduce coinsurance on a calendar year basis. The proposed rule required that the hospital must notify its fiscal intermediary of its election to reduce coinsurance no later than 90 days prior to the date the PPS is implemented or 90 days prior to the start of any subsequent calendar year and that the hospital's notification must be in writing. It must specifically identify the APC groups to which the hospital's election will apply and the coinsurance amount (within the limits identified below) that the hospital has elected for each group. The election of reduced coinsurance must remain in effect and unchanged during the year for which the election is made. Because the law states that hospitals may disseminate information on any reduced coinsurance amounts, we provided in the proposed rule that hospitals would be allowed to publicly advertise this information.

The proposed regulations provided that a hospital may elect to reduce the coinsurance amount for any or all APC

groups. A hospital may not elect to reduce the coinsurance amount for some, but not all, services within the same APC group.

As proposed, a hospital may not elect a coinsurance amount for an APC group that is less than 20 percent of the adjusted APC payment rate for that hospital. In determining whether to make such an election, hospitals should note that the national coinsurance amount under this system, based on 20 percent of national median charges for each APC, may yield coinsurance amounts that are significantly higher or lower than the coinsurance that the hospital previously has collected. This is because the median of the national charges for an APC group, from which the coinsurance amount is ultimately derived, may be higher or lower than the hospital's historic charges. Therefore, in determining whether to elect lower coinsurance and the level at which to make the election, we advise that hospitals carefully study the wage-adjusted coinsurance amounts for each APC group in relation to the coinsurance amount that the hospital has previously collected.

As discussed in section III.F.1, under sections 1834(d)(2)(C)(ii) and 1834(d)(3)(C)(ii) of the Act

the coinsurance for screening sigmoidoscopies furnished by hospitals and screening colonoscopies furnished by hospital outpatient departments and ASCs is 25 percent of the applicable payment rate. The payment rate for these colorectal cancer screening tests is the lower of the hospital outpatient rate or the ASC payment rate. The payment rate for screening barium enemas is the same as that for diagnostic barium enemas. However, the coinsurance amount for screening barium enemas is 20 percent of the APC payment rate. Hospitals may not elect to reduce coinsurance for screening sigmoidoscopies, screening colonoscopies, or screening barium enemas.

Calculation of coinsurance amounts on the basis of a hospital's election of reduced coinsurance is similar to the formula described in section III.F.3. For example, assume that the adjusted APC payment rate is $300; the program payment percentage for the APC group is 60 percent; the hospital has elected a $60 reduced coinsurance amount for the APC group; and the beneficiary has not satisfied the annual Part B deductible.

(A) Adjusted APC payment rate: $300

(B) Subtract the applicable deductible:

$300 - $100 = $200

(C) Multiply the remainder by the program payment percentage to determine the Medicare payment amount:

0.6 x $200 = $120

(D) Beneficiary's coinsurance is the difference between the APC payment rate reduced by any deductible amount and the Medicare payment amount, but not to exceed the lesser of the reduced coinsurance amount or the inpatient hospital deductible amount:

$200 - $120 = $80 (limited to $60 because of the hospital-elected reduced coinsurance amount)

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation.

$120 +$0 = $120

In this case, Medicare makes its regular payment of $120, and the beneficiary pays a $100 deductible and a reduced coinsurance amount of $60. The hospital receives a total payment of $280 instead of the $300 that it would have

received if it had not made its election to reduce coinsurance.

Comment: One commenter stated that it is currently illegal to accept lower coinsurance amounts from beneficiaries and asked for an explanation as to how we could propose to encourage hospitals to lower coinsurance.

Response: Although Medicare, in general, has prohibitions against reducing beneficiary coinsurance, redesignated section 1833(t)(8)(B) of the Act specifically provides the legal authority for hospitals to make elections to reduce coinsurance amounts for purposes of the outpatient PPS. However, those coinsurance amounts cannot be reduced below 20 percent of the adjusted APC payment rate for the hospital.

Comment: One commenter asked whether, in view of our proposal to allow hospitals to elect lower coinsurance, Medigap insurance plans will be permitted to offer a waiver of a participating hospital's coinsurance. That is, can a Medigap plan act as a preferred provider organization (PPO) with a financial incentive to select those hospitals that elect to reduce coinsurance?

Response: There are two kinds of Medigap policies--regular Medigap and Medicare SELECT. While regular Medigap

policies must pay full supplemental benefits on all claims that are submitted by all Medicare providers and are approved by Medicare carriers and intermediaries, Medicare SELECT plans, which are a managed care form of Medigap, may restrict payment of supplemental benefits to network providers. Thus, by design, Medicare SELECT plans are permitted to negotiate selectively with hospitals. Ordinarily, Medicare SELECT plans contract with certain hospitals to waive the hospital deductible for inpatient services.

Since the Congress has expressly permitted hospitals to reduce outpatient coinsurance to no less than 20 percent of the PPS payment amount, a Medicare SELECT plan is free to contract selectively with these hospitals. We note that a hospital's election to reduce coinsurance under redesignated section 1833(t)(8)(B) of the Act requires that the reduction be across-the-board for some or all APC groups. Thus, an agreement between a Medicare SELECT plan and a hospital to reduce coinsurance would result in coinsurance reductions for all beneficiaries who receive those APC group services at the hospital, whether or not they are enrolled in the Medicare SELECT plan.

Comment: One commenter requested that we seek a legislative change to offer hospitals more flexibility under the coinsurance reduction provision by permitting them to review and revise coinsurance amounts every 3 months.

Response: We believe that there would be a significant impact on contractors if hospitals were allowed to revise their reduced coinsurance more often than annually. More frequent coinsurance changes may also be confusing to beneficiaries. Because we do not have a good estimate of how many hospitals will make the elections and we do not yet know whether those hospitals that do make elections will elect to reduce coinsurance for just a few or for a significant number of APCs, we do not support allowing hospitals to make or change elections more often than annually. However, we may reconsider our position after we gain more experience under the PPS and can better assess what the impact of more frequent elections would be on hospitals, beneficiaries, and HCFA and its contractors.

Comment: One commenter noted that if we intend to publish a final rule no more than 90 days before implementation of the PPS, hospitals would not have sufficient time to make coinsurance election decisions. The

commenter recommended that hospitals be permitted to make the election 60 days before implementation of the system.

Response: This final rule will not be published more than 90 days before the date of implementation of the PPS. Therefore, the final regulations require that hospitals inform their fiscal intermediaries (FIs) of their elections to reduce coinsurance not later than June 1, 2000. Beginning with elections for calendar year 2001, elections are required to be made by December 1 preceding the calendar year. At this time, we do not know how many hospitals will choose to reduce coinsurance or for how many APCs these hospitals will elect reductions. While we want to provide hospitals sufficient time to make their elections, we also must provide fiscal intermediaries with enough time to incorporate the elections into their systems.

Comment: Several commenters disagreed with our proposal to allow hospitals to advertise reduced coinsurance amounts. They noted that, although the BBA 1997 provision with respect to hospitals' election to reduce coinsurance amounts provides that hospitals may "disseminate information" on their reductions, we have interpreted that to mean that hospitals may "advertise" their reductions.

Two commenters stated that disseminating information is not synonymous with granting one category of hospitals the unique opportunity to advertise to attract customers. They believe that this interpretation is antithetical to the spirit underlying provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prohibit beneficiary inducements and may conflict with State anti-kickback laws. Some commenters were also concerned that under our proposal to allow hospitals to advertise, hospitals may issue a general advertisement of reduced coinsurance when the reduction may apply only to certain services. Other commenters were concerned that hospital advertising may lead Medicare beneficiaries to believe that hospital outpatient care is more economical than other ambulatory settings, even when that is not the case, or beneficiaries may become confused and believe that all ambulatory providers have the ability to reduce coinsurance. These commenters asked us to reconsider our proposal to allow hospitals to advertise rather than to disseminate information. In addition, they asked us to establish additional requirements for hospitals' dissemination of information concerning coinsurance reductions so that

beneficiaries are made aware that reduced coinsurance applies only to certain specified services, that it applies only to coinsurance billed by hospitals for those services, and that the law does not permit reduced coinsurance for other Part B services such as physician services.

Several other commenters stated that for the election to reduce coinsurance to be effective, hospitals must have the right to advertise and, therefore, the commenters supported our proposal to permit hospitals to advertise coinsurance reductions.

Response: We believe that hospitals must be able to advertise their coinsurance reductions in order to achieve what we believe to be the intent of the BBA provision, that is, to provide hospitals with some ability to compete with other ambulatory settings (where coinsurance is already 20 percent of the applicable Medicare payment rate) and to reduce beneficiary coinsurance liability.

Hospitals would have less incentive to reduce coinsurance if they could not advertise. In addition, beneficiaries need to be fully informed so that they can make informed decisions. We believe that advertising as a way of disseminating information has merit.

We were persuaded by some commenters' concerns that beneficiaries may not understand that reduced coinsurance applies to specific hospital outpatient services furnished by specific hospitals that choose to elect reductions and that similar reductions cannot be made by other providers of ambulatory services. We, therefore, are amending the regulations to require that all advertisements or other information furnished to beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that these coinsurance reductions are available only where a hospital elects to reduce coinsurance for hospital outpatient services and reductions are not allowed in other ambulatory settings or physician offices.

Comment: One commenter, noting the complexity of the PPS coinsurance requirements, requested that we provide a phase-in period in the final rule to allow hospitals sufficient time to implement the changes necessary to meet the requirements.

Response: The method required to be used in calculating coinsurance under the PPS results in an overall decrease in the total coinsurance amounts beneficiaries pay

for hospital outpatient services. Total coinsurance is somewhat reduced in the first year of implementation and will be reduced even more in future years, until coinsurance for all PPS services equal 20 percent of the applicable APC payment rate. It is only by fully implementing the coinsurance provisions under section 1833(t)(3)(B) of the Act that beneficiaries will realize these reductions. We, therefore, do not support a phase-in period.

Comment: One commenter recommended that we include, as part of the public record, year by year estimates of the total economic burden placed on beneficiaries by the prolonged coinsurance phase-in period, assuming hospitals charge the maximum and minimum coinsurance amounts. The commenter believes these estimates would be useful as a basis for future discussions of how to remedy the coinsurance problem.

Response: As a rule, we develop estimates of impacts for legislative proposals that are under consideration by the Congress and for final legislation as we are developing regulations to implement the law. Although we do not have the resources available to model any number of other data analyses that may have merit, our data are made available to

the public, so the commenter and any other interested party may perform the coinsurance analysis.

Comment: One commenter stated that the proposed PPS creates new complexities for Medicare beneficiaries in that they will have to wait for hospitals to do the calculations necessary to determine coinsurance. The beneficiaries will also receive multiple bills and explanations of benefits for multiple hospital visits occurring on the same day. The commenter stated that we will need to have an extensive process in place to explain why, in most cases, beneficiaries are paying 50 to 70 percent of their outpatient services and why they are receiving separate statements when they have multiple visits on the same day.

Response: In the proposed rule, we assigned medical visits, that is, clinic and emergency room visits, to APCs based on both the level of visit as defined by a HCPCS code and the diagnosis of the patient. In order to implement that type of APC assignment, we would have to require hospitals to submit a separate bill for each medical visit that occurred on the same day; however, under the final rule, medical visits are assigned to APCs based solely on the HCPCS code, and it will be possible for hospitals to

bill for multiple medical visits on the same bill. We agree that the way coinsurance is determined under the PPS is a significant change. We are developing a brochure for beneficiaries that will explain the new system and the policies under the outpatient PPS that will affect them.

Comment: One commenter recommended that we make information available to beneficiaries that compares the average coinsurance for high volume procedures performed at hospitals in a particular geographic area so that beneficiaries can make informed health care decisions about their care.

Response: We believe that beneficiaries will be informed about the coinsurance reductions elected by hospitals in their area through advertisements and other information made available by hospitals.

Comment: One commenter asked whether the EOMB (Explanation of Medicare Benefits) notice to the beneficiary will clearly explain that a hospital's decision to reduce coinsurance applies to a specific service furnished at that specific hospital.

Response: We are reviewing the EOMB in light of the changes in Medicare payments and coinsurance amounts under

the PPS, but we have not yet finalized our work. We will take the commenter's suggestion into consideration as we investigate changes we will make to the EOMB.